DWS-ESD 61APP
Rev. 6/2009

State of Utah
Department of Workforce Services

PLEASE USE A BLACK BALL POINT PEN TO COMPLETE FORM

APPLICATION FOR FOOD STAMPS, FINANCIAL ASSISTANCE, CHILD CARE, AND MEDICAL ASSISTANCE

Esta solicitud también se encuentra disponible en Español

Case #: Expedited: ☐ Yes ☐ No

Your Information:

1. Fill out the following information for the **person requesting benefits**.

Name: _____
First Middle Last

Home Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

Phone #: _____ Birth Date: _____ Social Security #: (optional) _____

Email Address: _____

Signature:

2. Do you have a Utah Horizon card? ……☐ Yes ☐ No

Check The Services You Are Applying For:

☐ Food Stamps ☐ Cash/Financial Assistance ☐ Child Care

☐ Medical ☐ Retroactive Medical (last 90 days)

If you want to apply for unemployment benefits, log on to jobs.utah.gov or call (888) 848-0688.

Your Rights:

- **IF YOU NEED HELP FILLING OUT THIS APPLICATION, WE ARE HAPPY TO HELP.**
- **YOU HAVE THE RIGHT TO AN INTERPRETER FREE OF CHARGE.**
- You can turn in an application with only your name, address, and signature, but you must complete the entire application before we can determine you eligible for benefits.
- We will issue your assistance based on the date we receive your application. If your application is received outside business hours, it will be effective the following business day.
- For Child Care it is not mandatory for you to give your social security number or the social security numbers of the dependents in your household. If you choose not to give this information, your child care benefits will not be withheld or delayed if you meet all eligibility criteria.

Food Stamp and Medicaid Information for Immigrants:

- You can apply for and get food stamp and Medicaid benefits for eligible family members, even if your family includes other members who are not eligible because of immigration status. For example, immigrant parents may apply for food stamp benefits for their U.S. citizen or qualified immigrant children, even though the parents may not be eligible for benefits.
- You do not have to provide immigration status information, social security numbers, or documents for any family members who are not eligible for food stamp benefits because of immigrant status and who are not asking for food stamp benefits. Family members who are not eligible for food stamp or Medicaid benefits will still need to answer other questions about their name, relationship, income, assets, etc.
- Using food stamp benefits will not affect your immigration status or the immigration status of your family. Immigration information is private and confidential.
- Use of Medicaid benefits by you or your family members should not affect your ability to apply for permanent resident status unless you use Medicaid to pay for long-term care (nursing home or other institutionalized care). Use of Medicaid benefits will not affect your ability to apply for citizenship unless you committed fraud in getting those services.

D1630900027

3. Answer the following questions to help us decide if you can receive **food stamps within seven (7) calendar days**:

- Are you a migrant or seasonal farm worker?……☐ Yes ☐ No
- What is your household's monthly income before taxes (including unearned income such as child support Social Security, unemployment, etc.)?……$_____
- How much money do you have in cash and in the bank and/or credit union?……..$_____
- How much are your monthly housing costs (mortgage, rent, other)?……$_____
- Place a check mark by all of the utility costs you are responsible to pay. ___Heat ___Cooling (air conditioner, evaporative cooler) ___Electric (fan) ___Water/Sewer ___Garbage ___Telephone
- Have you applied for or received HEAT assistance in the last twelve months?……☐ Yes ☐ No

The following households are entitled to expedited services:
-Households whose combined monthly gross income and liquid resources are less than the household's monthly utilities and rent or mortgage.
-Some migrant and seasonal farm worker households
-Households with less that $150 in monthly gross income whose liquid resources (such as cash, savings, checking accounts) are no more than $100.

Let us know if you disagree with the decision made on your case about expedited food stamps and a meeting will be scheduled for you within two (2) working days.

4. Starting with yourself, list everyone who is living with you and **applying for benefits with you**:

Name	**Social Security #**	**Birth Date** and **Age**	**U.S. Citizen** Yes/No	**Relationship**	**Student** Yes/No	**Ethnicity** *see below	**Race** **see below	**Sex**	**Marital Status**
				Self					

*Ethnicity
H = Hispanic or Latino
N = Not Hispanic or Latino

**Race
AI = American Indian or Alaska Native
AS = Asian
BL = Black or African American
PI = Native Hawaiian or other Pacific Islander
WH = White

5. Are you and everyone applying with you Utah residents?……☐Yes ☐No

6. Do you or anyone applying with you have an authorized representative or someone who has legal power of attorney for you?……☐Yes ☐No

7. Are you or anyone applying with you living in one of these institutions?……☐Yes ☐No
☐Hospital ☐Shelter ☐Drug/Rehab Center
☐Group Home ☐Nursing Home ☐Jail-If yes, on work release?……☐Yes ☐No

8. Are you or anyone applying with you a fleeing felon?……☐Yes ☐No

OFFICE USE ONLY

_____Within 90 days for retro medical

9. Have you or anyone applying with you ever applied for/received financial or medical assistance or Food Stamp benefits?……☐Yes ☐No

Name:	Type of Assistance:	Where?	When?

10. Are you or any member of your household currently disqualified from the Food Stamp Program for any program violation?……☐Yes ☐No

11. Is there anyone else living with you who is not applying for benefits? If yes, list below:

Name:	Relationship to You:

12. What is the primary language spoken in your home?_____

13. Are you or anyone applying with you pregnant?……☐Yes ☐No
If yes, please list their name: _____ and due date: _____

14. Are you or anyone applying with you unable to work?……☐Yes ☐No
If yes, who? _____

15. Answering this question is not required for Food Stamps.
Are you or anyone applying with you a veteran?……☐Yes ☐No

Personal Assets:

16. Do you or anyone applying with you have any of the following financial assets?

$_____	Checking Account	☐	Time Certificates
$_____	Savings or Credit Union Account	☐	401-K/Other Retirement
☐	IRA	☐	Money Market Funds
☐	Stocks	☐	Trust Funds
☐	Bonds	☐	Other_____
☐	Annuities	☐	None

17. List all vehicles owned by you or anyone applying with you. Some examples of vehicles are cars, trucks, boats or water craft, motorcycles, snowmobiles, motor homes, ATV's, etc.:

Registered owner(s)	Type	Make	Year	Licensed Y/N	State	Amount owed

OFFICE USE ONLY

_____Alien #
_____Roomer
_____Boarder
_____Purchase & prepare
_____Strike

____Within 90 days for retro medical
____If pregnant and applying for medical, ask about tobacco use
____Complete tobacco survey if needed

____Disabled
____Status
____Duration
____Cancer Program

Asset Details

_____Sold, traded or given away any resources in last 30 days

_____Vehicle use

OFFICE USE ONLY

18. Do you or anyone applying with you have any of the following assets?

- ☐ Home
- ☐ Life Insurance
- ☐ Burial Plans/Funds
- ☐ Campers
- ☐ Time Shares
- ☐ Tools
- ☐ Rental or Investment Property
- ☐ Life Estate
- ☐ Land
- ☐ Mineral or Timber Rights
- ☐ Cemetery Plots
- ☐ Trailers
- ☐ Livestock
- ☐ Other _____
- ☐ None

19. Do you or anyone applying with you have any of the following unearned income?

- ☐ Social Security
- ☐ SSI
- ☐ Unemployment Benefits
- ☐ Child Support
- ☐ Lump Sum Payments
- ☐ Settlements
- ☐ School Financial Aid
- ☐ Retirement
- ☐ Workers' Compensation
- ☐ Veterans' Benefits
- ☐ Alimony
- ☐ Inheritances
- ☐ Other _____
- ☐ None

Income Details

____Cash Contribution
____Ever received or stopped receiving SSI
____Applied for unearned income

20. Do you or anyone applying with you have earned income?……☐Yes ☐No
If yes, provide information below:

Name of person working _____ Hourly Rate $_____
Employer Name _____ Hours worked per week _____
Self Employment ☐ Yes ☐ No Monthly Amount $_____

Name of person working _____ Hourly Rate $_____
Employer Name _____ Hours worked per week _____
Self Employment ☐ Yes ☐ No Monthly Amount $_____

Income Details

____Last worked/paid
____Pay frequency
____Work schedule
____Changes in hours worked or earnings expected
____Leave job or reduce hours in last 30 days
____Overlapping hours for 2-parent CC household

21. Do you or anyone applying with you have any of the following expenses? (Expenses must be reported and verified by your household to receive a deduction)

- ☐ Child Support
- ☐ Alimony
- ☐ Health Insurance

Total Expenses $_____per month

- ☐ Child Care
- ☐ Medical Expenses
- ☐ None
- ☐ Expenses for disabled person to work

OFFICE USE ONLY
____Receive help paying rent or other expenses
____How much
____From whom
____How meeting expenses
____Homeless

22. List housing expenses for you or anyone applying with you:

Rent $ _____ Mortgage $ _____ 2nd Mortgage $ _____ Lot Space $ _____

Taxes (yearly amount) $ _____ Insurance (yearly amount) $ _____ Other $ _____

Subsidized Housing ……☐Yes ☐No

23. Do you have heating and/or cooling expenses that are separate from your rent and/or mortgage payment?……☐Yes ☐No

24. Complete the following section if you are applying for Medical Assistance.

Check the appropriate box	**Insurance Information:**
☐ Yes ☐ No	Does anyone in your household currently have health insurance (including VA Health Care System benefits), or: - Have insurance available but not enrolled - Had insurance in the past 6 months **If yes, please complete the chart below.** *(Do not list Medicaid, Medicare, CHIP or PCN)*
☐ Enrolled ☐ Not enrolled, but available ☐ Ended, Date ended _____	Name of insurance company: _____ Phone #: _____ Address of insurance company: _____ Group #: _____ Policyholder name: _____ Policy #: _____ Policyholder date of birth: _____ Policyholder SS #: _____ If insurance is through an employer, list employer name and phone#: _____ Premium: $ _____ Date due: _____ How often? _____ Name of individuals covered (If not listed on the insurance card):
☐ Enrolled ☐ Not enrolled, but available ☐ Ended, Date ended _____	Name of insurance company: _____ Phone #: _____ Address of insurance company: _____ Group #: _____ Policyholder name: _____ Policy #: _____ Policyholder date of birth: _____ Policyholder SS #: _____ If insurance is through an employer, list employer name and phone#: _____ Premium: $ _____ Date due: _____ How often? _____ Name of individuals covered (If not listed on the insurance card):

Major Medical Need Information:

Does someone in your home have a major medical need?* ☐Yes ☐No If Yes, who? _____
*Pregnancy is considered a major medical need.

Check the type of incident	**Accident, Assault, or Other Liability**: If any household members have been injured in an accident, assault, or someone outside your household is required to pay for medical services, complete this section.
☐automobile ☐dog bite ☐assault ☐slip/fall ☐work-related ☐other* ☐medical malpractice	Name of household member: _____ Who is responsible? _____ Date of Incident: _____ Police department: _____ Police report #: _____ Name of attorney: _____ Phone #: _____ *Explain other:

I (print name)_____, read or had read to me the statements on the following four pages, Rights and Responsibilities. I understand those statements. I certify that the information/answers I have given on this application are complete and correct to the best of my knowledge. I also certify that the citizenship status information I provided is correct. I understand I can be penalized by law if I commit perjury by purposely giving false information on this application or fail to report changes.

Your Social Security Number and all other information you give will be subject to verification by federal, state, and local agencies. By signing this application, you are authorizing a release of information to conduct computer matches, program reviews, and audits with U.S. Citizenship and Immigration Services (formerly INS) and other federal and state agencies. Your Social Security Number may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. This also includes inquiries to any other organizations or individuals who may have eligibility information regarding you and other household members.

Signature or Mark of Customer Date

Signature of Authorized Representative Birth Date of Authorized Representative (Food Stamps only)

The following release is optional and failure to sign will not affect your Medicaid benefits. I authorize DWS to use any information gathered specifically for Medicaid eligibility, including medical information provided by a third party, to assist with my employment plan. This release is effective for the time period I am receiving employment counseling services from DWS.

Signature Date

- Return your application to your local Employment Center or Imaging Operations
  P.O. Box 143245
  Salt Lake City, UT 84114-3245
  Fax 801-526-9505 or toll free 1-888-522-9505

- Voter Registration: If you are not registered to vote where you live now, would you like to apply to register to vote here today?……☐Yes ☐No
  (If you do not check either of these boxes, you will be considered to have decided not to register to vote at this time.)

- If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided.

- If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Lt. Governor, State of Utah, 203 State Capitol Building, Salt Lake City, UT, 84114.

FOR OFFICE USE ONLY

_____ EBT Card	_____ Office Pathway
_____ Customer Education	_____ Rights and Responsibilities
_____ Medical Handouts	_____ CC Name of School, Traditional or Year Round
	_____ CC Training/Class Schedules
	_____ CC Training Completion Date ___Within 2 years

RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

- You have the right to be treated fairly and with courtesy, dignity, and respect.
- You have the right to an interpreter.
- We are prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability in accordance with federal law, U.S. Department of Agriculture (USDA) policy, and U.S. Department of Health and Human Services (DHHS) policy.
  - Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.
  - To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.
- Title VI of the Civil Rights Acts of 1964 allows us to ask for racial/ethnic information. You do not have to give us racial/ethnic information. If you do not want to give us this information, it will have no effect on your case. If you do not give us the information, the worker will enter an answer.
- You have the right to apply or reapply any time for any of the assistance programs offered by the Department of Workforce Services (DWS). Applications for CHIP, the Primary Care Network Program (PCN), and UPP are only accepted during open enrollment periods.
- You have the right to know if your application was approved or denied and the reasons for the decision.
  - For Food Stamps - benefits must be available to eligible household members no later than 30 days from the date of application.
  - For Medicaid, Financial and Child Care assistance, a decision will be provided within 30 days. If a disability decision is required for Medicaid approval may take up to 90 days.
  - For PCN/UPP/CHIP a decision will be provided within 30 days.
- You have the right to know if your assistance is reduced or ended. For food stamp benefits, there is one important exception to this rule. You will not receive advance notice of a food stamp benefit decrease if approved for financial assistance
- If you are in an institution and apply for Food Stamps and SSI at the same time, the filing date for Food Stamps will be the date of release from the institution.
- You have several options if you do not agree with the decisions made regarding your case, you may:
  - Talk to your worker to make sure you are not misunderstanding each other.
  - Talk to your worker's supervisor.
  - Call DWS Customer Relations at: 801-526-4390 or 800-331-4341.
  - Request a Fair Hearing verbally or in writing with an impartial Hearing Officer. You must provide a written request for Fair Hearing for Medical assistance.
  - Free legal advice is available from Utah Legal Services. In Ogden call 801-394-9431, Salt Lake City 801-328-8891, or toll free at 800-662-2538. A referral for legal advice is available from Salt Lake Lawyer Referral at 801-531-9075.
- You have the right to privacy in your home. DWS may not enter your home without your permission or use coercion or force to enter your home. DWS may not visit you after working hours without an appointment.
- The Department of Workforce Services may contact you, or have someone contact you, about the effectiveness of services you received.
- You have the right to access your case record information.
- You have the right to receive information regarding registering to vote and may request help to complete the voter registration form.

- The information you provide on your application may be disclosed to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

YOUR RESPONSIBILITIES

- You must report changes that affect your eligibility for assistance programs. Your worker will provide you specific information on changes you must report when your application is approved.
- You must provide the Social Security number of each household member requesting assistance, with the exception of child care, CHIP and Emergency Medicaid. If you do not have a number, you must provide proof of applying for a number. You can receive assistance while you are waiting to receive a number.
- You must cooperate with any review of your case by Quality Control and/or DWS.
- You must have an interview and provide the information necessary to prove you are eligible for assistance. If you do not understand what is required, or if you cannot give the necessary information, please let your worker know.
- If you are approved for financial assistance, you will need to sign over to the Office of Recovery Services any child support, medical support, or alimony you would have received on behalf of your household during the time you are getting assistance. Child support and alimony will be used to offset the costs of providing financial assistance for your household.
- If you receive medical assistance, you must tell DWS, if you have health insurance. You may be required to enroll in a medical health plan.
- Parents have the responsibility to support their minor children until they are emancipated by turning age 18, married, or otherwise directed by court order. Parents who receive financial, or medical are required to cooperate with child and medical support orders and collections. Unless you can provide good cause for not cooperating.
- If the Utah Department of Health (UDOH) pays for your medical care, you assign to it your rights to payments from any third party and to benefits for medical services. You will give to the UDOH any money you collect from an insurance policy, legal settlement or from someone required to pay for your medical expenses. You authorize payment directly to the UDOH or the Office of Recovery Services and will hold harmless any party making payment to them. You agree to cooperate with the State of Utah to pursue any third party responsible for medical expenses.
- You authorize any person or organization to release medical records or information about your health or the health of your dependents to the UDOH, Division of Health Care Financing or designee. The UDOH and the Department of Workforce Services may give health care providers information about your eligibility for medical assistance.
- The State has the right to recover from your estate all money spent to pay your medical bills if you receive Medicaid at any time while you are 55 years of age or older
- You agree that the assistance you receive under any medical program is limited to that described in the Provider Manuals that the Utah Department of Health has written. You understand that the benefits you are eligible to receive may be changed without your knowledge or consent. You further agree to be responsible for any co-pays to providers at the time of medical service unless you are exempt from those co-pays.
- Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS HelpLine at 801-538-6872 or the Immunization Hotline at 1-800-275-0659.
- If you receive benefits for which you are not eligible, you must pay them back.
- If you choose a license-exempt child care provider, the state of Utah does not regulate or monitor the child care. We can give you more information about how to choose a quality child care provider.

VERIFICATION OF INFORMATION

- For all those applying for benefits, your Social Security Number, as well as other information you give us, will be subject to verification using the State Income and Eligibility Verification System. DWS will ensure that your household is eligible for food stamps and other federal assistance programs through electronic matches. Computer matching, program reviews and audits will be conducted with DWS, Department of Homeland Security, Social Security Administration and Internal Revenue Service records. It also includes inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information regarding you and other household members.
- Computer matches will be completed when you apply and after you receive assistance. Your food stamp, financial, child care and medical benefits may be reduced, denied or terminated because of information from these sources.

THINGS YOU SHOULD KNOW

- We don't count all of your earnings. Your earnings are NOT deducted dollar-for-dollar from your benefits. Each program has a different way of calculating earnings. Please ask an eligibility worker for a detailed explanation of the way we determine eligibility for each program.
- When your income has increased enough that you no longer get financial assistance, you may continue to get medical assistance, food stamps, and child care if you meet certain requirements. Ask your employment counselor for more information.
- Child care assistance is intended to pay for child care services provided. It may not cover the full cost of care. If you do not use your child care assistance to pay your provider for eligible services, you will be required to return the money to DWS. Depending upon the type of provider you select, you will either receive a two party check or transfer the funds to them using your Utah Horizon Card.
- You may be paid some benefits on a Horizon Card. The card is protected by a personal identification number (PIN). If you give the card and PIN to anyone, you will be responsible for any withdrawals made from the card. If you lose the card or if it is stolen, report it to DWS immediately. Call the Horizon Card Helpdesk at (800) 997-4444. You will be responsible for any withdrawals from your lost or stolen card until you report it to DWS.

OBEY PROGRAM RULES

- All the members of your household must obey the program rules and provide complete and accurate information. Do not give food stamp benefits to anyone who has no right to use them or purchase ineligible items. Do not use other individuals' food stamp benefits unless you are the authorized representative.
- If you break any of these rules, you may be disqualified from receiving food stamp benefits, child care or financial assistance.
  - The first time you violate a rule, you may not be eligible for these benefits for 12 months.
  - The second rule violation may result in a 24 month disqualification.
  - The third time, you may be ineligible permanently for food stamp, child care or financial program benefits. You may also be prosecuted under other laws.
  - There may also be a fine up to $250,000 or a jail sentence up to 20 years.
- Knowingly providing false information or fraudulent participation in any program may result in criminal or civil action and/or administrative claims.
- If you use food stamp benefits to buy or sell controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) you will be disqualified from the Food Stamp Benefit program for 24 months for the first offense and permanently as a result of a second offense.
- If Food Stamps are used to buy or sell firearms, ammunition, or explosives the disqualification from the Food Stamp Program is permanent.
- You will be permanently disqualified from the Food Stamp Benefit program if convicted of trafficking food stamp benefits of $500 or more.
- If you sell food you purchased with your Food Stamp benefits, you will be disqualified from the Food Stamp program for 12 months for the first offense, 24 months for the second offense, and permanently for any additional offenses.
- You will be disqualified for Food Stamps, Financial and Child Care programs for 10 years each for the first and second offenses if you make a fraudulent statement regarding your identity and residence to get multiple benefits. The third offense will result in permanent disqualification.

IMPORTANT INFORMATION ABOUT YOUR MEDICAL CARD

- You will receive a medical card every month. This card proves that you are eligible for medical services:
  - Keep your card in a safe place.
  - Have your medical card ready to show before receiving treatment.
  - If you lose your card, report it to the local office and another card will be mailed to you.
  - Do not let anyone else use your card.
  - Check to see if Medicaid covers it. If it is not, you will be responsible for the bill.
- You must accept generic prescription drugs instead of brand-name prescription drugs:
  - Medicaid will not pay for brand-name prescription drugs unless the doctor writes "Do Not Substitute" on the prescription. The doctor must be able to explain why the generic drug is not acceptable.

- Medicaid is the “payor of last resort.” This means that any other source of payment for your medical bills must be used first. Medicaid will only pay after Medicare, private health insurance and auto or accident insurance has paid their respective portion. If someone else is responsible for paying for your medical care, for example your spouse, parent(s) or someone who injured you in an accident, that person must pay first.
- Medicaid will send payments directly to the doctors or medical providers. The medical provider should NOT send a bill to you if Medicaid covered the service unless you used the medical expense to meet your spenddown.
- Doctors and medical care providers may share information regarding your health with DWS. DWS may release information regarding your medical eligibility status to health care providers. When you signed the application form, you agreed to this release of information.
- CHIP (Children’s Health Insurance Program) can provide medical examinations for your children. Please speak with your Health Program Representative for further information regarding CHIP.
- All applicants applying for dependent children are to receive information about the Child Health Evaluation and Care (CHEC) program.
- Co-Payments - A co-payment is a fee a Medicaid recipient will be charged for certain Medicaid services. Recipients must pay the co-payments directly to the Medicaid provider at the time of service. The following people are exempt from co-payments:
  - children under age 18
  - pregnant women (verified with worker)
  - residents of a nursing home or medical institution
  - individuals with gross household income under the FEP payment level for their family size (FEP payments are counted as income.)
- If the Medical Disability Office decides you are disabled, and you are later denied by Social Security, your case must be closed. It may be reopened if you file an appeal. You may also ask the Medical Disability Office to reassess your situation if you have a new disabling medical condition that was not originally considered.
- If you owe a spenddown or other fee to receive medical assistance, you must pay such amount to DWS to be eligible. DWS cannot accept payments from Medicaid providers for your spenddown or other fee that you owe. DWS will accept payments if the provider is your representative payee and the payment is made with your funds.
- If you spenddown and your medical expenses are less than your spenddown, ask for a refund. It can take up to one year to get a refund. Any money that you owe DWS will be deducted from the refund.
- You may be able to use medical bills to meet your spenddown obligation. If you are enrolled in a Medicaid Health Plan, you cannot use medical bills incurred in the same month as your Medicaid card.
- If you have paid for any of the items listed below, or have the ability to pay for any of these items, please tell your eligibility worker. You may be entitled to special deductions that decrease your spenddown:
  - Health insurance premiums.
  - Billed necessary medical expenses for a family member who does not get Medicaid.
  - Billed necessary medical expenses that cannot be paid by your insurance company or Medicaid.
  - We will allow unpaid bills or prescriptions. If they have been paid, they may be allowed depending upon when they were paid.
- Information regarding you and your case is confidential. DWS has specific rules regarding the kind of information which may be shared and with whom it may be shared. For example, we may give information about you to other agencies if they need the information to administer a program to assist you. Otherwise, the break of your trust is a Class B misdemeanor of which the penalty is a fine of at least $100, but less than $1,000.